Affidavit of Records Custodian of The Back & Neck Institute

THE DACK & NECK INSTITUTE
STATE OF TEXAS § COUNTY OF EL PASO §
COUNTY OF EL PASO §
Before me, the undersigned authority, personally appeared (Custodian of Records Name)
My name is Julia Quanta am of sound mind and capable of making this affidavit, and personally acquainted with the facts herein stated.
I am the custodian of records for The Back & Neck Institute. Attached to this affidavit are records that provide an itemized statement of the service and the charge for the service that The Back & Neck Institute provided to DAWN CORDERO on October 11, 2016 to Present , the attached records are part of this affidavit.
The attached records are kept by The Back & Neck Institute in the regular course of business, and it was the regular course of business of The Back & Neck Institute for an employee or representative of for The Back & Neck Institute , with knowledge of the service provided, to make the record or transmit information to be included in the record. The records were made in the regular course of business at or near the time reasonably soon after the time the service was provided. The records are the original or duplicate of the original.
The services provided were necessary and the amount charged for the services was reasonable at the time and place that the services were provided.
The total amount paid for the services was \$ and the amount currently unpaid but which for The Back & Neck Institute has a right to be paid after any adjustments or credits is \$ (Custodian of Records Signature)
SWORN TO AND SUBSCRIBED before me on the day of, 2018
Valeria A. Flores Notary ID: 131364003 My Commission Expires: December 1, 2021 Notary Public, State of Texas
Notary's printed name: \(\(\lambda\)\(\rangle\)\(\rangl





HEALTH INSURANCE CLAIM FORM		EL PASO 1X 79901	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0	2/12		ε
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CORDERO, DAWN	07 05 1995 M FX	HOWDYS	
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
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PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to process this claim. I also request payment of government benefits e	the release of any medical or other information necessary ther to myself or to the party who accepts assignment	payment of medical benefits to the und services described below.	
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SIGNATURE ON FILE	DATE 10/17/17	SIGNATURE SIGNATURE	ON FILE
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15. OTHER DATE	16. DATES PATIENT UNABLE TO WORK	IN CURRENT OCCUPATION
MO 10 16 QUAL 431	QUAL 454 09 28 17	FROM	то
NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a OB MDK4281TX	18. HOSPITALIZATION DATES RELATED	TO CURRENT SERVICES
DN ROBERT E URREA MDPA	176. NPI 1356303150	FROM	то
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	SO TX 79925-3413	EL PASO TX 79925	
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HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUICC) 02/12		FLORES TAWNEY A 801 MYRTLE AVE S EL PASO TX 79901	COSTA PC UITE 100
1. MEDICARE MEDICAID TRICARE CHAMPI		1a. INSURED'S I.D. NUMBER	PICA []
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, Firs	t Name, Middle Initial)
CORDERO, DAWN	07 05 1995 M FX	HOWDYS	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
1880 JOAN FRANCIS DR	Self X Spouse Child Other	12460 MONTWOOD D	
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EL PASO TELEPHONE (Include Area Code)	-	ZIP CODE TELL	EPHONE (Include Area Code)
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79928	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR F	ECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	e. EMPLOYMENT? (Current or Previous)	a, INSURED'S DATE OF BIRTH	SEX
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RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by N	
	X YES NO 1 1		
RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROC	GRAM NAME
	YES X NO	FLORES TAWNEY AC	COSTA PC
INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BEN	
		YES X NO If yes,	complete Items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETIN PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either below.	release of any medical or other information necessary to myself or to the party who accepts assignment	 INSURED'S OR AUTHORIZED PEF payment of medical benefits to the u services described below. 	
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SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FA	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #	(915)8818264
		THE BACK & NECK	INSTITUTE
•	GEMERE SUITE 1	6211 EDGEMERE SU	JITE 1
SIGNATURE ON FILE EL PASC	TX 79925-3413	EL PASO TX 79925	5-3413

DATE

07/13/18

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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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. MEDICARE MEDICAID TRICARE CHAMPA [(Medicare#) (Medicaid#) (ID#/DoD#) (Member)	- HEALTH PLAN - BUK LUNG -	ta. INSURED'S I.D. NUMBER	(For Program in Item 1)
. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name	, First Name, Middle Initial)
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READ BACK OF FORM BEFORE COMPLETING 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the			D PERSON'S SIGNATURE I authorize the undersigned physician or supplier for
to process this claim. I also request payment of government benefits either below.		services described below.	. C. C. STORY OF BUILDING OF BUILDING TOL
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7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178		18. HOSPITALIZATION DATES R	ELATED TO CURRENT SERVICES
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9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ2(7x00000x	20. OUTSIDE LAB?	\$ CHARGES
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PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12			PICA 🗀
. MEDICARE MEDICAID TRICARE CHAMPY	A GROUP FECA OTHER	ta, INSURED'S I.D. NUMBER	(For Program in Item 1)
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. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name	e, First Name, Middle Initial)
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: PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., S	Street)
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RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR	PROGRAM NAME
	YES X NO	FLORES TAWNEY	ACOSTA PC
INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH	BENEFIT PLAN?
		YES X NO	If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the			D PERSON'S SIGNATURE I authorize
to process this claim. I also request payment of government benefits either below.		payment of medical benefits to services described below.	o the undersigned physician or supplier for
	DATE 08/30/18	STCNATI	URE ON FILE
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	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO &	PH# (915)8818264
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DECREES OR CREDENTIALS (I certify that the pattern into or the revise apply to this bill the are material part thereof.) 6211 EI		THE BACK & NI	
apply to this bill the are mater apart thereof. 6211 EI	OGEMERE SUITE 1	6211 EDGEMER	
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ICC Instruction Manual available at: www.nucc.org	PLEASE RAINT OF TYPE	A STATE OF THE PARTY OF THE PAR	MB-0938-1197 FORM 1500 (02-



FLORES TAWNEY ACOSTA PC 801 MYRTLE AVE SUITE 100 EL PASO TX 79901

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA PICA T MEDICARE MEDICAID TRICABE CHAMPVA GROUP HEALTH PLAN (ID#) OTHER 1a. INSURED'S I.D. NUMBER FECA BLK LUNG (ID#) (For Program in Item 1) X (ID#) (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX INSURED'S NAME (Last Name, First Name, Middle Initial) 07 05 1995 CORDERO, DAWN CORDERO, DAWN 5. PATIENT'S ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Spouse Child 1880 JOAN FRANCIS DR 1880 JOAN FRANCIS DR CITY STATE 8. RESERVED FOR NUCC USE STATE PATIENT AND INSURED INFORMATION ELTХ ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code) 79928 79928 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10: IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER a, OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX X NO Fχ YES 07 05 1995 b. RESERVED FOR NUCC USE b, AUTO ACCIDENT? b. OTHER CLAIM ID (Designated by NUCC) PLACE (State) YES X NO c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME X YES NO FLORES TAWNEY ACOSTA PC d. INSURANCE PLAN NAME OF PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete Items 9, 9a, and 9d READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for to process this claim. It also request payment of government benefits either to myself or to the party who accepts assignment services described below. SIGNATURE ON FILE SIGNED 11/27/18 SIGNATURE ON FILE DATE SIGNED 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD 10 11 16 QUAL 431 09 28 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18, HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17a OF MDK4281TX 17b. NPI DN ROBERT E URREA MDPA 1356303150 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES ZZ207X00000X YES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) 22. RESUBMISSION ICD Ind. ORIGINAL REF. NO. A.L. M24852 B. L. M79605 c. L M7062 D. 23. PRIOR AUTHORIZATION NUMBER E. L F. L G. I H. I K. L 24. A. DATE(S) OF SERVICE D. PROCEDURES, SERVICES, OR SUPPLIES B C. PHYSICIAN OR SUPPLIER INFORMATION From DIAGNOSIS Tο PLACE OF RENDERING (Explain Unusual Circumstances) ID. DD SERVICE CPT/HCPCS MODIFIER POINTER \$ CHARGES PROVIDER ID. QUAL NPI NPI NPI NPI NPI 25, FEDERAL TAX I.D. NUMBER 27. ACCEPT ASSIGNMENT? SSN FIN 26, PATIENT'S ACCOUNT NO. 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use YES INO S \$ 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.) 40943 <u> 225000</u> 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # (915)8818264 THE BACK NECK INSTITUTE THE BACK & NECK INSTITUTE 6211 EDGEMERE SUITE 1 6211 EDGEMERE SUITE 1 SIGNATURE ON FILE EL PASO TX 79925-3413 PASO TX 1265499578 b 1265499578

DATE

11/27/18

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SIGNED



FLORES TAWNEY ACOSTA PC 801 MYRTLE AVE SUITE 100 EL PASO TX 79901

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE	EE (NUCC) 02/12	
PICA		PICA []
1. MEDICARE MEDICAID TRICARE	CHAMPVA GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) (Medicald#) (ID#/DoD#)	(Member ID#) HEALTH PLAN (ID#) X (ID#)	(i or i region in tent i)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial		- NAVE
· · · · · · · · · · · · · · · · · · ·	MM I DD I YY	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
CORDERO, DAWN	07 05 1995 ML FX	CORDERO, DAWN
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1000 7033 5533055 55	Self Spouse Child Other	
1880 JOAN FRANCIS DR		1880 JOAN FRANCIS DR
CITY	STATE 8. RESERVED FOR NUCC USE	CITY STATE
EL PASO	TX	EI DAGG
ZIP CODE TELEPHONE (Include A		ZIP CODE TELEPHONE (Include Area Code)
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79928		79928 ()
9. OTHER INSURED'S NAME (Last Name, First Name, Mic	ddle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
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. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	YES X NO	•
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THEORITIES FOR NUCL USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
	X YES NO	FLORES TAWNEY ACOSTA PC
. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
	Tob. OBTINE OODEG (Designated by NOGC)	
		YES NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFOR	RE COMPLETING & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	E I authorize the release of any medical or other information necessary	payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government	ant benefits either to myself or to the party who accepts assignment	services described below.
below.		
SIGNEDSIGNATURE_ON_FILE	DATE 10/11/10	CTONAMUDE ON DITE
	DATE 12/11/18	SIGNED SIGNATURE ON FILE
A. DATE OF CURRENT ILLNESS, INJURY, or PREGNANI	ICY (LMP) 15. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
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NAME OF REFERRING PROVIDER OR OTHER SOUR	454 09 28 17	
I	17a. OP MDK4281TX	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
DN ROBERT E URREA MDPA	176 NDI	FROM
9. ADDITIONAL CLAIM INFORMATION (Designated by NU	1356303150	20. OUTSIDE LAB? \$ CHARGES
	zz207x00000x	SCHANGES
		YES X NO
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	ICD Ind.	CODE ORIGINAL REF, NO.
. <u>М24852</u> в. <u>М79605</u>	с. <u>Г. м70.62 —</u> р. <u>Г </u>	
- F.L	G. L	23. PRIOR AUTHORIZATION NUMBER
J	K.L L.L	
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FEDERAL TAX I.D. NUMBER SSN EIN 2	26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 2	
	(For govt. dalms, see back)	29. AMOUNT PAID 30. Rsvd for NUCC L
742930397	CORDAGOS 141510 YES NO	5 50d00 S
SIGNATURE OF PHYSICIAN OR SUPPLIER 3		2 BILLING BROVIDED INFO & BH # /
INCLUDING DEGREES OR CHEDENTIALS		(915) 8818264
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements of the reverse apply to this bill and are mide a pair Negrot).)	THE BACK NECK INSTITUTE	THE BACK & NECK INSTITUTE
apply to this bill and are made a part bereof.	1	
U	6211 EDGEMERE SUITE 1	6211 EDGEMERE SUITE 1
SIGNATURE ON FILE	EL PASO TX 79925-3413	EL PASO TX 79925-3413
SNED 12/11/18 DATE a.	(C) time t	1265499578 b
	TO THE POST OF THE	1.2.CEMODE 7.0.10

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AFFROYED BY MATIONAL DIGIFORM CDAIM COMMITTEE (NUCC) 02/12	:		
PICA			PICA TT
1. MEDICARE MEDICAID TRICARE CHAMP	- HEALTH PLAN - BLK LING -	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
(Medicare#) (Medicald#) (ID#/DoD#) (Member	IDH) (IDH) X (IDH)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Nam	e, Middle Initial)
CORDERO, DAWN	07 05 1995 M F X	CORDERO, DAWN	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
1880 JOAN FRANCIS DR	Self Spouse Child Other	1880 JOAN FRANCIS	מח
CITY STATE		CITY	STATE
EL PASO TX		EL PASO	
ZIP CODE TELEPHONE (Include Area Code)			DNE (Include Area Code)
70000		1)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	79928 \ 11. INSURED'S POLICY GROUP OR FECA	/
The state of the s	IN IS PANER (S CONDITION REDATED TO:	11. INSURED'S POLICY GROUP ON FECA	NUMBER
8. OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYACHTE (Oursel or Best dates)		
a. OWIEN INCOMEDO! COO! ON GROOM NOWDER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX
b. RESERVED FOR NUCC USE	YES X NO	071 0511995	M F X
S. NEOENTED TON MOOD ODE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
- BERCHUED FOR MUCOLUM	YES X NO		
c. RESERVED FOR NUCC USE	o. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM	NAME
	X YES NO	FLORES TAWNEY ACOS	TA PC
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT	PLAN?
A STATE OF THE STA		YES X NO If yes, comp	plete Items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETIN 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the	G & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON	
to process this claim. I also request payment of government benefits either	to myself or to the party who accepts assignment	payment of medical benefits to the unders services described below.	signed physician or supplier for
below.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
SIGNED SIGNATURE ON FILE	DATE01/09/19	SIGNED SIGNATURE OF	N FILE
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10 11 16 QUAL 431	AL 454 MM DD 1 YY 09 28 17	FROM DD YY	TO DD YY
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 174		18. HOSPITALIZATION DATES RELATED TO	
DN ROBERT E URREA MDPA 17			O L TY
O ADDITIONAL OF THE INTERPRETATION OF THE PARTY OF	7X00000X		CHARGES
2220	7/X00000X	YES X NO	1
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to sen	ica line below (24F)		
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	142404 X YES NO CILITY LOCATION INFORMATION	\$ 650000 \$	
INCLIDING DESCREES OF COEDENTIALS	SURGERY CENTER		915) 8818264
apply to this bill and are made a part thereof.)		THE BACK & NECK IN	STITUTE
	GEMERE STE2	6211 EDGEMERE SUIT	E 1
	TX 79925-3413	EL PASO TX 79925-3	3413
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JCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OF TYPE	APPROVED OMB-0938-	1107 FORM 1500 (02.10)



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IEALTH INSURANCE CLAIM FORM

FLORES TAWNEY ACOSTA PC 801 MYRTLE AVE SUITE 100 EL PASO TX 79901

CARRIER APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 GROUP HEALTH PLAN (ID#) OTHER 18. INSURED'S I.D. NUMBER MEDICARE FECA BLKLUNG MEDICAID TRICARE **CHAMPVA** (For Program in Item 1) X ((D#) (Medicare#) (Medicald#) (ID#/DoD#) (Member ID#) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX INSURED'S NAME (Last Name, First Name, Middle Initial) 07 05 1995 M CORDERO, CORDERO, DAWN DAWN 5. PATIENT'S ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other 1880 JOAN FRANCIS DR 1880 JOAN FRANCIS DR STATE 8. RESERVED FOR NUCC USE CITY STATE AND INSURED INFORMATION EL PASC TX PASO ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code) 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11: INSURED'S POLICY GROUP OR FECA NUMBER a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) A. INSURED'S DATE OF BIRTH SEX FX IYES X NO 07 05 1995 b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? b. OTHER CLAIM ID (Designated by NUCC) PLACE (State) YES X NO PATIENT c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? C. INSURANCE PLAN NAME OR PROGRAM NAME XYES NO FLORES TAWNEY ACOSTA PC d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES XNO If yes, complete items 9, 9a, and 9d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary
to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE 01/16/19 SIGNATURE ON FILE SIGNED DATE SIGNED 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM 1 DD QUAL. 09 28 431 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES REFERRING PROVIDER OR OTHER SOURCE OB MDK4281TX NPI ROBERT E URREA MDPA 1356303150 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES ZZ207X00000X YES ON X 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) 22. RESUBMISSION ICD Ind. ORIGINAL REF. NO A. L. M24852 в. L M79605 c. LM7062 D. 23. PRIOR AUTHORIZATION NUMBER E. J F. I G. I H. K. I DATE(S) OF SERVICE 24. A. B C. D. PROCEDURES, SERVICES, OR SUPPLIES G. DAYS OR UNITS SUPPLIER INFORMATION From DIAGNOSIS To LACEO (Explain Unusual Circumstances) ID. RENDERING CPT/HCPCS DD мм DD SERVICE EMG MODIFIER POINTER S CHARGES QUA PROVIDER ID. NPI NP NPI OHO NPI **PHYSICIAN** NPI NPI 25. FEDERAL TAX I.D. NUMBER SSN FIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Asvd for NUCC Use Ś X YES 142718 42930387 50d00 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR OPEDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 33. BILLING PROVIDER INFO & PH # 32. SERVICE FACILITY LOCATION INFORMATION (915) 8818264 THE BACK NECK INSTITUTE THE BACK & NECK INSTITUTE 6211 EDGEMERE SUITE 1 6211 EDGEMERE SUITE 1 PASO TX 79925 SIGNATURE ON FILE PASO TX 79925 1265499578 265499578 SIGNED



ACOSTA PC FLORES TAWNEY 801 MYRTLE AVE SUITE 100

EL PASO TX 79901 HEALTH INSURANCE CLAIM FORM APPROVEÓ BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA I PICA OTHER 1a. INSURED'S I.D. NUMBER CHAMPVA GROUP HEALTH PLAN (ID#) (For Program in Item 1) MEDICARE MEDICAID TRICARE EEX LUNG X (IDA) (Medicald#) (Member IDII) (Medicare#) (ID#/DoD#) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 07 05 1995 CORDERO, DAWN м FIX CORDERO, DAWN 7. INSURED'S ADDRESS (No., Street) 5. PATIENT'S ADDRESS (No., Street) 6 PATIENT RELATIONSHIP TO INSURED Spouse Child Other X 1880 JOAN FRANCIS DR 1880 JOAN FRANCIS DR STATE 8. RESERVED FOR NUCC USE CITY CITY STATE PATIENT AND INSURED INFORMATION EL PASO тX ELPASO TELEPHONE (Include Area Code) ZIP CODE ZIP CODE TELEPHONE (include Area Code) 79928 79928 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a, INSURED'S DATE OF BIRTH a. OTHER INSURED'S POLICY OR GROUP NUMBER a, EMPLOYMENT? (Current or Previous) SEX FX YES X NO 07 05 1995 M 6. AUTO ACCIDENT? b. RESERVED FOR NUCC USE b. OTHER CLAIM ID (Designated by NUCC) PLACE (State) YES X NO c. RESERVED FOR NUCC USE c. OTHER ACCIDENTS c. INSURANCE PLAN NAME OR PROGRAM NAME X YES INO FLORES TAWNEY ACOSTA PC d, INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 10d. CLAIM CODES (Designated by NUCC) X NO IYES If yes, complete items 9, 9a, and 9d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary payment of medical benefits to the undersigned physician or supplier for to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment rvices described below. SIGNATURE ON FILE 01/31/19 SIGNED SIGNATURE ON FILE SIGNED DATE 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM | DD | \ 09 28 17. 10 11 16 QUAL TO QUAL. 431 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17 NAME OF REFERRING PROVIDER OR OTHER SOURCE OB MDK4281TX TO 17b. NPI ROBERT E URREA MDPA 1356303150 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20, OUTSIDE LAB? \$ CHARGES ZZ207X00000X YES NO X 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) 22. RESUBMISSION ICD Ind. ORIGINAL REF. NO AL M546 D. 23. PRIOR AUTHORIZATION NUMBER E. L G. L K. I DATE(S) OF SERVICE C, D. PROCEDURES, SERVICES, OR SUPPLIES PHYSICIAN OR SUPPLIER INFORMATION В. RENDERING PLACE OF (Explain Unusual Circumstances) DIAGNOSIS ID. MM DD DD SERVICE POINTER SCHARGES OLIA PROVIDER ID. (NPI 01 NPI NPI NPI NPI NPI 30. Rsvd for NUCC Use 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28, TOTAL CHARGE 29. AMOUNT PAID 143042 X YES S 5 X 225000 742930387 CORDA005 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I cortify that the state hand of the reverse apply to this bill and an made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH . (915)8818264 THE BACK NECK INSTITUTE THE BACK & NECK INSTITUTE 6211 EDGEMERE SUITE 1 6211 EDGEMERE SUITE 1

PASO TX 79925-3413

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1265499578

DATE

SIGNATURE ON FILE

01/31/19



APPROVED BY NATIONAL	. UNIFORM CLAIM	COMMITTEE (NUCC)	02/12

AT THOUSE OF THE THE COURT OF	OT HAS CERTAIN QUINNESS (LL (11000) 02 12										V-1
PICA												PICA
1. MEDICARE MEDICAID	TRICARE	CHAMPV	HEAL	TH PLAN	FECA BLK LUNG	2	1a. INSURED'S I.D. N	IUMBER			(For Program li	n Item 1)
(Medicare#) (Medicald#)	(ID#/DoD#)	(Member II	(IDII)	10000	(IDII)	X (ID#)						
2. PATIENT'S NAME (Last Name,	•	val)	3. PATIENT	BIRTH DATE		SEX	4. INSURED'S NAME	(Last Nam	e, First Na	ame, Mi	ddle initial)	
CORDERO, DAWN			07 0	5 1995	м	F X	CORDERO	DAW	N			
5. PATIENT'S ADDRESS (No., St	eet)		6. PATIENT	RELATIONSHI	P TO INSU	IRED	7. INSURED'S ADDR	ESS (No.,	Street)			
1880 JOAN FRA	NCIS DR		Self X	Spouse	hild	Other	1880 JO	AN FR	ANCIS	S DR	*	
CITY		STATE	8. RESERVE	D FOR NUCC	USE		CITY					STATE
EL PASO		TX					EL PASO					TX
ZIP CODE	TELEPHONE (Include						ZIP CODE		TELEPI	HONE (Include Area C	
79928	()						79928		1 -1	١	١.	
9. OTHER INSURED'S NAME (La	st Name, First Name, I	Middle Initial)	10. IS PATIF	NTS CONDITI	ON RELAT	ED TO:	11. INSURED'S POLI	CY GROUI	PORFEC	A NIIM	AED .	
		,						o, a	0.11.40	ilt.		
a. OTHER INSURED'S POLICY O	R GROUP NUMBER		a. EMPLOVA	IENT? (Current	t or Previou	ıa)	a. INSURED'S DATE	OE BIDTU			SEX	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					,	MM I DD	, YY		мΓ	_	e Tool
b. RESERVED FOR NUCC USE			b. AUTO AC	YES	Хио		07 05					FX
			3. AUTO MUI		_	LACE (State)	b. OTHER CLAIM ID	(Designate	d by NUC	(C)		
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c. RESERVED FOR NUCC USE			c. OTHER AC				c. INSURANCE PLAN					
				YES	NO		FLORES T				A PC	
d, INSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM (CODES (Design	nated by N	UCC)	d. IS THERE ANOTH	ER HEALT	H BENEF	IT PLAN	1?	
595							YES _}	NO	If yes, co	mplete i	items 9, 9a, and	d 9d.
READ E	ACK OF FORM BEFO	ORE COMPLETING	& SIGNING T	HIS FORM.	Information	n necesser	13. INSURED'S OR A					
to process this claim. I also requ							payment of medica services described	i below.	uie UNO	ersigne	n huàrici a u ot t	supplier for
below.	_			0008-3	sastrer voor							
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17. NAME OF REFERRING PROV	TOER OR OTHER SO	JRCE 17a.	OH MI	OK4281T			18. HOSPITALIZATIO	N DATES	RELATED	TO CU	RRENT SERV	ICES,
DN ROBERT E U	RREA MDPA	17b.		3563031			FROM P	י ו "	1	то	MM DD	11
19. ADDITIONAL CLAIM INFORM	ATION (Designated by	NUCC)					20. OUTSIDE LAB?	-	-	\$ CHA	RGES	
		2220	7X0000	UX			YES 7	ON			1	
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r. I	B	U			D		23. PRIOR AUTHORI	ZATION NI	UMBER			
E. L.	VICE	_ G.∟			H. L							
24. A. DATE(S) OF SERVICE	J. L.	C. D. PROCE	DURES, SERV	ICES, OR SUF	PPLIES :	E.	F.	T G	TH.	1- 1	J	
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25. FEDERAL TAX I.D. NUMBER	SSN EIN	28. PATIENT'S A	CCOUNT NO.	27. AC	CEPT ASS	IGNMENT?	28. TOTAL CHARGE	29	. AMOUN	T PAID	30. Rsvd	l for NUCC Us
742930387	X	CORDA00	5 143			NO	\$ 740	00	3	1		i
31. SIGNATURE OF PHYSICIAN (32. SERVICE FA					33. BILLING PROVID		PH#	919	88182	64
31. SIGNATURE OF PHYSICIAN O INCLUDING DEGREES OF CE (I certify that the statements on apply to this bill and by made	REDENTIALS the reverse	THE BAG	CK NEC	K INS	TITUT	E	THE BAC	K & N	IECK			J.
apply to this bill and are made	part thereof.)	6211 EI	GEMERE	SUITE	1		6211 ED					
SIGNATURE ON		EL PASC					EL PASO					
			99578			* = -	a. 1265499			51		
SIGNED 02/20/19	DATE	12054	770/8	W		~	1205498	2101		general lines	67 FORM	



. MEDICARE MEDICAID TRICARE CHAMPY	A GROUP FECA CITIER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicarell) (Medicaidll) (ID#/DoD#) (Member)	HEALTH PLAN BLK LUNG	(or registration ()
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
CORDERO, DAWN	07 05 1995 M FX	CORDERO, DAWN
. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1880 JOAN FRANCIS DR	Self X Spouse Child Other	1880 JOAN FRANCIS DR
STATE	8. RESERVED FOR NUCC USE	CITY STATE
EL PASO TX	-	EL PASO TX
TELEPHONE (Include Area Code)	ì	
79928 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	79928))
. OTHER MOUNED'S NAME (Last Name, Filst Name, Millione India)	10. 15 FAMENT 5 CONDITION RELATED TO:	The state of the s
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a, INSURED'S DATE OF BIRTH SEX
	YES X NO	07 05 1995 M FX
. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	YES X NO	
, RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	C, INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	FLORES TAWNEY ACOSTA PC
INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
	· · · · · · · · · · · · · · · · · · ·	YES X NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING 2, PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the	release of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits either below.		services described below.
STONATION ON PITE	DATE 04/11/19	SIGNATURE ON FILE
SIGNED	OTHER DATE	SIGNED
MM / DD / YY	AL 454 09 28 17	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD DD TO TO TO
	0B MDK4281TX	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
DN ROBERT E URREA MDPA		FROM TO MM OB TY
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ20	7X00000X	20. OUTSIDE LAB? \$ CHARGES
		YES X NO
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serv	ICD Ing.	22. RESUBMISSION ORIGINAL REF. NO.
<u>в. М24852</u> в. <u>М79605</u> с. L	M7062 D.L	
F.L G. L	н. 🗀	23. PRIOR AUTHORIZATION NUMBER
. L J. L K.L	L L	F. Q. H. I. J.
	DURES, SERVICES, OR SUPPLIES E. DIAGNOSIS	DAYS EPSOT ID. RENDERING
MM DD YY MM DD YY SERVICE EMG CPT/HCF	CS MODIFIER POINTER	S CHARGES UNITS Pan QUAL PROVIDER ID. #
3 29 19 03 29 19 11 19921	5 ABC	500 00 1 NPI 1356303150
13 129 ДЭ 03 29 ДЭ 11 1 1 1 1 1 1 1 1	S III	[
		NPI NPI
		NPI NPI
		NPI NPI
	(1)	NPI NPI
		
C EEDERAL TAVID NUMBER SOM EIN DE PATIENTE	ACCOUNT NO. 27 ACCEPT ASSIGNMENTS	NPI NPI 29, TOTAL CHARGE 29, AMOUNT PAID 30, Rsyd for NUCC
5. FEDERAL TAX I,D. NUMBER SSN EIN 26. PATIENT'S A	(For govi. claims, see back)	
742930387 X CORDA005	5 144982 X YES NO	\$ 50000 \$
INCLUDING DEGREES OR CREDENTIALS THE BAC		33. BILLING PROVIDER INFO & PH # ('915) 8818264 THE BACK & NECK INSTITUTE
(I certify that the statements on the reverse apply to this bill end are made a part thereof.) 6211 E.E.	OGEMERE SUITE 1	6211 EDGEMERE SUITE 1
CTCNATURE ON ETTE	TX 79925-3413	EL PASO TX 79925-3413
		DI FROU IN 199413
O4 11/19 a. 126545	9578 b.	a 1265499578 a